

Timbrook Public Safety Center
231 East Piccadilly Street, Ste. 330
Winchester, VA 22601

Telephone: (540) 662-2298
FAX: (540) 542-1318
Website: www.winchesterva.gov

Reporting a Work Related Injury

Please follow the updated/revised instructions for reporting work related injuries. If reporting an on-the-job injury or illness, the following procedures apply to all City employees:

- Do not delay calling Coventry Workers' Comp Services NT24 Nurse Triage at 1-877-234-0898, the City of Winchester Member Number is 169. Complete the nurse triage information sheet and sign the panel of physicians form. Send completed forms to the office.
- Workers' Compensation Packet includes: Nurse Triage Information Sheet, Panel of Physicians Form, Work Comp Medical First Report, Workers' Comp First Fill Prescription Form Instructions and Prescription Card Form. This packet must be completed for all injuries.

Nurse Triage Information Sheet:

- Form can be found at: <http://fire.winchesterva.gov/>
- Forms are to be returned and signed 24 hours post-accident.
- ALL injuries must be reported by supervisor and employee to the Coventry Workers' Comp Services NT24 Nurse Triage at 1-877-234-0898 and all paperwork must be returned to the office.
- If professional medical attention is required, a registered nurse will determine the best course of action based on the symptoms reported.
- Supervisors must provide a detailed description of the accident and injuries/illness.
- Employees are required to sign the nurse triage information sheet and the panel of physicians form.

Panel of Physicians Form Last Revised June 2012:

- Form can be found at : <http://fire.winchesterva.gov/>
- Supervisors must give all employees the opportunity to read, sign and retain a copy of the Panel of Physicians list for all on-the-job injury or illness claims.
- All employees must be given the opportunity to sign the form after each minor or major injury or illness; otherwise the employee may be giving up their benefits.
- Supervisors are encouraged to make a copy of this form and give it to the employee for future medical treatment.

Prescription Card Form:

- Form can be found at : <http://fire.winchesterva.gov/>
- VML has instituted a prescription card plan for workers' compensation claimants that can be used with a valid paneled physician's prescription. If an employee needs a workers' compensation prescription filled, the employee can use this one time card at any pharmacy.
- Employees do not pay any out-of-pocket expense for a valid workers' compensation prescription.
- Read Workers' Comp First Fill Prescription Form Instructions
- Supervisors need to complete the Name and Social Security Number (SS#) on the Prescription Card Form.

Special Notes for Supervisors:

- VML Policy – if the workers' compensation claim is delivered within 24 hours and an employee seeks medical attention with a POP doctor, VML will pay the initial visit regardless of compensability or later denial.
- Employees are responsible for paying any invoice regarding a missed workers' compensation doctor appointment.
- Supervisors shall not prejudice any worker's rights to file a workers compensation claim out of disbelief, revenge or any other willful behavior.
- The Emergency Room may be used for injuries after-hours. Employees must follow up with one of the doctors listed on the Panel of Physicians.

Supervisors: In case of an injury your responsibilities are:

For minor injuries....

- Provide first-aid
- Complete the Nurse Triage Information Sheet and sign a Panel of Physicians Form
- Have supervisor and employee call Coventry Workers' Comp Services NT24 Nurse Triage
- Forward completed paperwork to the office

For moderate and severe injuries....

- Provide first-aid
- Secure the accident scene
- Call ahead to medical provider
- Accompany employee to medical provider
- Complete Nurse Triage Information Sheet
- Have employee sign Panel of Physicians Form
- Accompany employee
 - home, if he/she cannot return to work due to injury
 - back to work, apply restriction if appropriate

If Medical Attention is needed:

- Employee needs to take the Work Comp Medical First Report and have it completed by the physician and return the completed form to the office along with any other paper work received
- The Prescription Card needs to be used for any prescriptions that are given to avoid any out-of-pocket expense

Employee Injury Check List

If you are injured you should:

- Notify your supervisor
- Complete the Nurse Triage Information Sheet
- Sign the Panel of Physicians
- Call Nurse Triage (NT 24) at 1-877-234-0898, City of Winchester Member Number 169
- Seek medical attention if necessary at a participating Panel Physician or ED after normal business hours (ED visits will require follow-up meeting with a participating Panel Physician)
- Supply the participating Panel Physician with the description of required firefighter physical activities
- Have the Work Comp Medical First Report Completed by participating Panel Physician and return to work form completed with any additional paperwork then forward to Fire and Rescue administration attention Safety 6
- Report to Fire and Rescue administration immediately after medical attention is received from the participating Panel Physician
- Administration will review the physician's recommendations and decide if light duty is an option or if time-off is required
- Use the prescription card form at the pharmacy for any prescriptions that were prescribed to avoid any out-of-pocket expense
- If the injury happened on an incident; you need to enter the information in the Firehouse report under the casualty report for that incident
- If the injury was not on an incident; you need to request an incident number from ECC, have ECC enter the location of the injury as the address and use Safety 6 as the unit (this should be completed the same day as the injury)
- You need to notify the following staff of the injury via e-mail; Fire Chief, Deputy Chief of EMS, Deputy Chief of Operations, Health and Safety Officer

Nurse Triage Information Sheet

Important: The employee **MUST** see a medical provider on the attached Panel of Physicians if there is any question about his or her medical condition.

Coventry Workers' Comp Services NT24 - Nurse Triage - 1-877-234-0898
City of Winchester Member Number 169

Report Number: _____ Medical Attention Needed: Yes _____ No _____

Employee Name (last name first): _____ SSN# _____

Home Address: _____ Zip: _____

Home Phone#: _____ Work Phone#: _____ D.O.B. _____

Date of Injury/Illness: _____ Location: _____

Time: _____ ☐ a.m. ☐ p.m.

Dept: _____ Job Title: _____

Incident Description: _____

Nature of Injury/Illness (including body part affected): _____

Name of Witness: _____

First-Aid Treatment Administered by: _____

Describe First-Aid Treatment: _____

Actual/Anticipated return to work date: _____

Supervisor's Signature _____ Date _____

Employee Signature _____ Date _____

WINCHESTER, CITY OF WORKERS COMPENSATION PANEL OF PHYSICIAN

THE CLOSEST EMERGENCY FACILITY MAY BE USED IN AN EMERGENCY SITUATION. ONCE THE EMERGENCY TREATMENT IS COMPLETED A PANEL PHYSICIAN MUST BE CHOSEN FOR FOLLOW-UP CARE.

_____ I agree to select a doctor, if needed, from the below panel.

_____ I have declined to select a physician from the below panel. I understand that I will have to pay for any medical treatment or doctor's bills, and that I will be denied workers' compensation coverage for any absence based on a disability which is not certified by an approved panel physician.

Signature of Employee

Date

Signature of Supervisor

Date

Valley Health Occupational Services
607 East Jubal Early Drive
Winchester, VA 22601

Kevin Culbert, DO

540-536-2200

Amherst Family Practice
1867 Amherst St
Winchester, VA 22601

Harry Nelson III Gustin, MD
Megan Williams, DO
Patricia Houser, MD
William Bender, MD

540-667-8724

MedExpress Martinsburg Urgent Care Center
83 Retail Commons Parkway
Martinsburg, WV 25403

Etosha Dickson, MD
Kolawale Oshiyoye, MD
William Dressler, MD

304-264-9730

MedExpress Martinsburg, WV Urgent Care Center
1355 Edwin Miller Blvd. Suite A
Martinsburg, WV 25404

Ambroz Allesandro, MD
Etosha Dickson, MD
John Giangola, MD
Kathryn Reihard, MD
Mikela Swenson, MD
Reed Erickson, MD

304-263-6753

WINCHESTER, CITY OF WORKERS COMPENSATION PANEL OF PHYSICIAN

MedExpress Urgent Care Winchester
207 Gateway Drive
Winchester, VA 22603

Ralph Rickel, MD

540-535-1029

Medics USA - Winchester
290 Front Royal Pike
Winchester, VA 22602

Khodaidad Basharmal, MD

540-662-5300

Mountain View Family Medicine
33674 Old Valley Pike
Strasburg, VA 22657

Thomas Edward Holthus, DO

540-465-3751

Valley Health Occupational Services
97 Administrative Drive
Martinsburg, WV 25404

Kirsten Zeiss, MD
Nandita Subedi, MD

304-350-3200

Valley Health Urgent Care
607 East Jubal Early Drive
Winchester, VA 22601

Kirsten Zeiss, MD
Mark R Jones, MD

540-536-2232

Valley Health Urgent Care & Occupational Health
Warrenton
120 N Commerce Ave
Front Royal, VA 22630

Laura Lawson, DO

540-635-0700

Winchester Urgent Care
2505 Valley Avenue
Winchester, VA 22601

Harjit Bagri, MD

540-665-0084

WINCHESTER, CITY OF WORKERS COMPENSATION PANEL OF PHYSICIAN

Specialist Panel

Hands * This panel is to only be used after the employee was referred to a specialist by a general practitioner above.

Bone & Joint Specialists of Winchester
190 Campus Blvd #310
Winchester, VA 22601

Martin Baechler, MD

540-667-9252

Orthopaedic

Bone & Joint Specialists of Winchester
190 Campus Blvd #310
Winchester, VA 22601

Dwight Kemp, DO
James Larson, MD
Richard Patterson, MD
Thomas Courtney, MD
William Cooper, DO

540-667-9252

Winchester Orthopaedic Associates
128 Medical Circle
Winchester, VA 22601

Abbey Gore, MD
Stephen Martenson, MD
Thomas Wise, MD
Winston O Cameron, MD

540-667-8975

Orthopaedic Back and Spine

Winchester Orthopaedic Associates
128 Medical Circle
Winchester, VA 22601

John Zoller, III, MD

540-667-8975

Required Firefighter Physical Activities: The physical demands described here are representatives of those that must be met by an employee to successfully perform the essential functions of the job. Firefighting requires considerable physical effort working continuously with average and frequently heavy weight. The requirements listed below are frequent and may be exercised for long periods of time, and are not limited to climbing, balancing, flexing, stooping, kneeling, crouching, walking, running, jumping, crawling, lifting, pushing and hoisting.

Work Comp Medical First Report

1. To be completed by the treating physician - Please send completed forms to VML Insurance Programs - **fax 800-273-4865**
2. Please provide the patient with a copy of the completed form.
3. Patient, provide your supervisor with a copy of this form after treating.

Patient's Name: _____

Patient's Address: _____

Name of Employer: City of Winchester

Date of Accident or Illness: ____/____/____

Patients account of How Injury or Exposure Occurred: _____

Name of Medical Facility: _____

Date of Visit: ____/____/____ Arrival Time: _____ AM/PM Departure Time: _____ AM/PM

Diagnosis: _____

New Injury/Illness ☐ Existing Condition ☐

* * * * *

Recommended Work Status:

A) May return to full duty beginning: ____/____/____

B) May return to modified duty beginning: ____/____/____

▪ Recommendation based on:

_____ personal review of functional job description

_____ verbal description of job by employee/patient

_____ verbal description of job by employer representative

_____ other (describe: _____)

▪ The employee/patient is **medically able** to do the following activities:

▪ Does condition preclude travel to and from work ☐ Yes ☐ No

▪ Does condition preclude being at work ☐ Yes ☐ No

▪ Anticipate return to full duty beginning: ____/____/____

C) Unable to work at this time ☐

▪ Anticipate return to modified duty beginning: ____/____/____

▪ Anticipate return to full duty beginning: ____/____/____

Physician's Comments (Please note any contributing factors, prior injuries and pre-existing conditions):

Follow-Up Appointment with: _____ Date: ____/____/____ Time: _____ AM/PM

To ensure payment, any follow-up care must be authorized by VML Insurance Programs

Physician/Clinician Name (please print): _____ Phone # _____

Physician/Clinician Signature: _____



Workers' Compensation First Fill Prescription Form Instructions

With this form, a 7 to 10 day supply of medication will be provided to the injured employee at no cost. Instruct the injured employee to take this form to a network pharmacy and present this to the pharmacy with their prescription(s).

There are more than 61,000 pharmacies nationwide in the network, 1500+ in Virginia. The network includes all major chains (CVS, Rite Aid, Walgreen, Wal-Mart, K-Mart, Target, etc.) as well as most of the medium and small local pharmacies (Gaunts Drugstore, Inc, Martins Pharmacy, Medical Arts Pharmacy, etc.). To view the pharmacy network or find a local pharmacy, visit the website www.modernmedical.com. Scroll down; the bottom left corner of the website is a pharmacy location feature (as well as a drug lookup).

Once the claim is received and reviewed by VML Insurance Programs (VMLIP), VMLIP will let the pharmacy provider know if the claim is accepted or denied. If accepted, the remaining supply of medication will be filled. Any future prescriptions the injured employee needs will be direct billed through the pharmacy provider. A pharmacy representative will also contact the injured employee and explain the process. If the claim is denied, there is no financial consequence to the injured employee for the first fill.

Important Information and Instructions for providing a first fill form to an injured employee:

- This form is for workplace injuries only and for City of Winchester employees only
- A workers' compensation claim must be reported to NT24; 1-877-234-0898 (City of Winchester VMLIP Member Number is 169)
- Pre-fill the employee's name and SSN before providing this form to the employee
- Only provide this form to an employee after the initial treatment when medication is prescribed
- If the claim is reported late or the employee waits to seek treatment (a week or more following the injury), do not provide the employee with this form, have the employee contact their VMLIP representative; 1-800-963-6800
- This form is valid for one time use only. Do not provide an employee with additional forms for the same injury. For additional medication beyond the first fill, the injured employee must contact their VMLIP representative: 1-800-963-6800.



**Instant Coverage Workers'
Compensation Prescription
Program**

Plan, Carrier, Group: VML169

Employer: City of Winchester

Employee's Name: _____

Employee's SS#: _____

Attention Pharmacist

Please retain for your records; billing is through InformedRx



Customer Service: 1-800-547-3330

BIN No. 610011

PCN: IRX

Covered medications include only
Those normally used in Workers'
Compensation injury cases.

**Process prescriptions through
InformedRx**

Administered By:

Modern Medical, Inc. 1-800-547-3330

Instructions for Prescription card: ① Write in employee's name and Social Security Number. ② Give card to pharmacist along with prescription written by physician. ③ Card is valid for first fill of prescription only and will deactivate after first use. ④ Should an employee encounter problems, immediately contact Modern Medical at 1-800-547-3330 ⑤ Refills must be authorized by VML Insurance Programs.

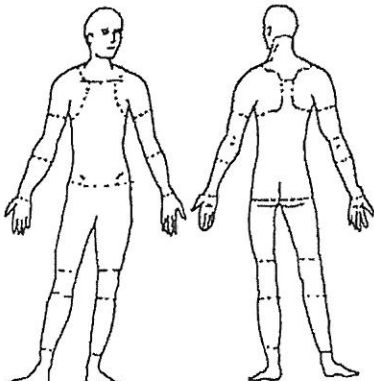
One Less Thing To Worry About

7840 Graphics Way, Lewis Center, Ohio 43035 • 740-657-3330 • 800-547-3330 • 877-247-3330 toll-free fax



EMPLOYEE INCIDENT REPORT FORM

- All job-related injuries or illnesses – regardless of extent call 1-877-234-0898 to speak to a nurse 24/7, 365 days a year.
- Report the accident immediately to your supervisor and a physician chosen from the PANEL OF PHYSICIANS must be used if medical treatment is needed.
- If a panel physician is unavailable at the time of an emergency, an emergency facility may treat you; however, any follow up care must be rendered by the physician chosen by you from the Panel of Physicians.
- In addition to calling the nurse hotline above, **this form must be completed by the employee and supervisor and emailed to Michael.Bozeth@winchesterva.gov within 24 hours of all incidents.**

First Name:		Last Name:		Job Title:																																											
Date of Injury:	Hour:	AM <input type="checkbox"/> PM <input type="checkbox"/>	Time Left Work:	AM <input type="checkbox"/> PM <input type="checkbox"/>	Employee Number:																																										
Department Name:		Name of Supervisor:		Date Reported to Supervisor:																																											
Exact Location of Accident:				Name of Witness:																																											
Describe Accident (What was injured worker doing; what objects, machines or materials were involved):																																															
Regular Days Off:		Working Shift AM <input type="checkbox"/> to AM <input type="checkbox"/> PM <input type="checkbox"/> to PM <input type="checkbox"/>																																													
What part of your workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities																																															
<input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other _____																																															
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<input type="checkbox"/> OTHER _____			<input type="checkbox"/> RESPIRATORY	<input type="checkbox"/> OTHER _____																																											
Please circle part(s) of body affected																																															

Employee Signature: _____

Date: _____

SUPERVISOR'S INVESTIGATION OF INCIDENT

Result of Incident:

☐ FIRST AID CASE ONLY
☐ REQUIRED DOCTOR'S CARE

☐ HOSPITALIZED
☐ RECORD ONLY

☐ TIME LOSS
☐ DEATH

Did you personally view the incident site?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Employee Category	<input type="checkbox"/> Part Time	<input type="checkbox"/> Full Time	<input checked="" type="checkbox"/> Temporary
Names of witnesses (if any):					
Written witness statements/photographs/maps / drawings attached?					
What personal protective equipment was being used (if any)?					
Description continued on attached sheets: <input type="checkbox"/>					

UNSAFE ACTS

- | | |
|---|---|
| <input type="checkbox"/> OPERATING WITHOUT AUTHORITY
<input type="checkbox"/> FAILURE TO WARN OTHERS

<input type="checkbox"/> OPERATING OR WORKING AT UNSAFE SPEED
<input type="checkbox"/> MAKING SAFETY DEVICES INOPERATIVE
<input type="checkbox"/> FAILURE TO SECURE OBJECTS

<input type="checkbox"/> USING UNSAFE EQUIPMENT OR EQUIPMENT UNSAFELY
<input type="checkbox"/> UNSAFE LOADING, LIFTING, CARRYING
<input type="checkbox"/> TAKING UNSAFE POSITION OR POSTURE | <input type="checkbox"/> HORSEPLAY
<input type="checkbox"/> FAILURE TO USE PERSONAL PROTECTIVE DEVICES
<input type="checkbox"/> FAILURE TO OBSERVE SAFETY REGULATIONS
<input type="checkbox"/> LACK OF TRAINING OR KNOWLEDGE
<input type="checkbox"/> PREVENTABLE VEHICLE ACCIDENT
<input type="checkbox"/> SLIPS AND FALLS
<input type="checkbox"/> FAILURE TO LOCK OUT/TAG OUT
<input type="checkbox"/> OTHER: _____ |
|---|---|

UNSAFE CONDITIONS

- | | |
|--|--|
| <input type="checkbox"/> IMPROPERLY GUARDED EQUIPMENT OR MACHINE
<input type="checkbox"/> DEFECTIVE TOOL OR EQUIPMENT
<input type="checkbox"/> POOR HOUSEKEEPING

<input type="checkbox"/> IMPROPER LIGHTING

<input type="checkbox"/> IMPROPER VENTILATION (DUST, FUMES, ETC.)
<input type="checkbox"/> UNSAFE DESIGN OR CONSTRUCTION
<input type="checkbox"/> SLIPPERY OR OTHER UNSAFE SURFACE | <input type="checkbox"/> INADEQUATE WARNING SYSTEM
<input type="checkbox"/> HAZARDOUS STORAGE OR ARRANGEMENT
<input type="checkbox"/> HAZARDOUS DRESS OR APPAREL
<input type="checkbox"/> HAZARDOUS WORK PROCEDURE
<input type="checkbox"/> HAZARDOUS WEATHER OR ENVIRONMENT
<input type="checkbox"/> CONTACT WITH POISONOUS PLANTS, INSECTS, TOXIC CHEMICALS, SKIN IRRITANTS, BITES, ECT.
<input type="checkbox"/> OTHER: _____ |
|--|--|

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there is a shortcut (such as "the job can be done more quickly" or "the product is less likely to be damaged" that may have encouraged the unsafe conditions or acts? ☐ Yes ☐ No

If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No

Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No

What changes do you suggest to prevent this incident from happening again?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Stop this activity
<input type="checkbox"/> Redesign task steps
<input type="checkbox"/> Routinely inspect for the hazard | <input type="checkbox"/> Guard the hazard
<input type="checkbox"/> Redesign work station | <input type="checkbox"/> Train the employee(s)
<input type="checkbox"/> Write a new policy/rule
<input type="checkbox"/> Personal Protective Equipment | <input type="checkbox"/> Train the supervisor(s)
<input type="checkbox"/> Enforce existing policy
<input type="checkbox"/> Other: _____ |
|--|---|--|---|

What should be (or has been) done to carry out the suggestion(s) checked above?

IF WARRENTED, WHAT PRACTICAL CORRECTIVE ACTION WILL BE TAKEN BY SUPERVISION TO PREVENT RECURRENCE?

Note: The wording "be more careful" is unacceptable, as it does not present a viable solution. If the cause is properly identified, there should be several solutions.

SUPERVISOR'S SIGNATURE _____

DATE _____

MANAGEMENT REVIEW SIGNATURE _____

DATE _____

DEPARTMENT HEAD'S SIGNATURE _____

DATE _____